Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROC HOUSTON PA
4126 SOUTH WEST FREEWAY SUITE 330
HOUSTON TX 77027

Respondent Name
SEABRIGHT INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-4879-01

MFDR Date Received
AUGUST 22, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The benefits for this medical bill were significantly reduced due to Carrier's determination that the billed CPT code 11012 is bundled into the value of another CPT code for the same date of service in addition to reducing and paying a lesser amount for the remaining CPT codes. Based on the circumstances of this case, we sent a request for reconsideration stating that the CPT code be considered for separate reimbursement and not bundled under payment for the procedure but, carrier denied the request."

Amount in Dispute: $1,408.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has billed $5,316.90 for the services rendered, and submits it is entitled to reimbursement in the amount of $2563.40. The provider billed using Code 11012-59, 26735, and 26418. The carrier has determined the correct reimbursement rate is $1743.78. The carrier approved $1177.15 for Code 26735. This was the primary procedure, and this reimbursement rate is consistent with the applicable fee guidelines. The carrier approved $566.63 for Code 26418 based upon the multiple procedure rule and the applicable fee guidelines. No reimbursement was allowed for Code 11012-59 because that procedure is considered 'global' to another service/procedure from the same date of service, and it is not reimbursed separately ."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2011	CPT Code 11012-59-F1	$1,408.17	$439.53

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 663-Reimbursement has been calculated according to the state fee schedule guidelines.
   - ST-P-State/Province Pricing
   - 850-048-Based upon clinical review by our onsite medical staff, this service/procedure is being denied as inclusive of another service/procedure billed on this day.
   - CR-A-Clinical review adjustment.

Issues

1. Is the requestor entitled to reimbursement for CPT code 11012-59?

Findings

1. The respondent denied reimbursement for the disputed service based upon reason code "850-048."

   CPT code 11012 is defined as "Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone".

   On the disputed date of service the requestor also billed code 26418 and 26735. Per CCI edits, code 11012 is not a component of code 26418; therefore, reimbursement is recommended.

   28 Texas Administrative Code §134.203(b)(1), states "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77004, which is located in Harris County.

   The formula to determine MAR is (2011 DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount

   The 2011 DWC Conversion Factor is for surgery performed in a facility 68.47.

   The Medicare Conversion Factor is 33.9764

   The Participating Amount for code 11012 in a facility is $436.21.

   (68.47/33.9764) X $436.21 = $879.06

   CPT code 11012 is subject to multiple procedure rule discounting of 50%.

   $879.06 X 50% =$439.53

   The MAR for CPT code 11012 in Harris County is $439.53. The respondent paid $0.00; Therefore, the requestor is due $439.53.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $439.53.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $439.53 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/05/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.